Your Medicare Handbook

Important:
If you are receiving kidney dialysis or kidney transplant services, there is a supplement to the Medicare handbook which describes how Medicare pays for services for the treatment of permanent kidney failure. You can get a copy of the supplement, *Medicare coverage of kidney dialysis and kidney transplant services*, from any social security office. For all other covered services you receive, use this Medicare handbook for the information you need.

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Contents

How to use Your Medicare Handbook

This is *Your Medicare Handbook*. It tells you what Medicare is and how it works. Keep the handbook where you can find it. Then, when you need medical care, you can use the handbook to find out whether the services you need are covered by Medicare and how much Medicare can pay.

Medicare will help pay for many of your health care expenses, but not all of them. You should know in advance what expenses Medicare does not cover. On pages 42 and 43 there is a list of the services and supplies Medicare cannot pay for and some that Medicare can pay for only under certain conditions.

Page 48 tells you how to submit your medical insurance claims, and beginning on page 52 there is an address list showing where to send your claims.

Page 39 tells you what to do if you think there has been a mistake in a Medicare decision or the amount of payment.

As you read the handbook, you will see stars (*) by some words. A star means there is a footnote at the bottom of the page that will give you additional information.

There is also an index at the back of the book. If you want to know about a particular subject, look it up in the index to find out what page it's on.

This is the 1976 edition of the handbook. If you have an earlier copy of the handbook, please throw it away. As changes occur in the Medicare program, we will keep you informed.

Whenever you can't find information you need in this handbook, call a social security office. Look up Social Security Administration in your telephone book to get the number of a social security office near you.

What is Medicare

Medicare is a health insurance program for people 65 and older and some people under 65 who are disabled. It is a Federal Government program run by the Social Security Administration. Medicare has two parts. One part is called hospital insurance. The other part is called medical insurance.

Medicare's hospital insurance (sometimes called Part A) can help pay for medically necessary inpatient hospital care, and, after a hospital stay, for inpatient care in a skilled nursing facility and for care in your home by a home health agency.

Medicare's medical insurance (sometimes called Part B) can help pay for medically necessary doctors' services, outpatient hospital services, outpatient physical therapy and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare. Medical insurance also can help pay for necessary home health services when hospital insurance cannot pay for them.

You are responsible for part of the cost of some services covered under Medicare. The amounts or the share of the costs for which you are responsible are described in this handbook. As general health care costs rise, these amounts may increase. We will keep you informed of any changes in the amounts you have to pay under Medicare. If you cannot pay these amounts or for other health care expenses, you may be able to get help from the Medicaid program in your State.

Medicare payments are handled by private insurance organizations under contract with the Government. Organizations handling claims from hospitals, skilled nursing facilities, and home health agencies are called **intermediaries.** Organizations handling claims from doctors and other suppliers of services covered under the medical insurance part of Medicare are called **carriers.**

Your Medicare card

Be sure you keep the Medicare health insurance card we sent you in the mail. The card shows the Medicare protection you have (hospital insurance, medical insurance, or both) and the date your protection started. If you don't have both parts of Medicare, see page 44 to find out how you can get the part you don't have.

The card also shows your health insurance claim number. The claim number has 9 digits and a letter. In some cases, there will be another number after the letter. Be sure to put your full claim number on all Medicare claims and correspondence. If a husband and wife both have Medicare, they get separate cards and different claim numbers. Each must use the exact claim number shown on his or her card.

Important things to remember

- Always show your Medicare card when you receive services that Medicare can help pay for.
- Always write your health insurance claim number (including the letter) on any bills you send in and on any correspondence about Medicare.
- Carry your card with you whenever you are away from home. If you ever lose it, ask the people in the social security office right away to get you a new one.
- Do not use your Medicare card before the effective date shown on your card.
- Permanent Medicare cards made of metal or plastic, which are sold by some manufacturers, are not a substitute for your officially issued Medicare card.

Who can provide services or supplies under Medicare

To help make sure that health care furnished to Medicare beneficiaries is of acceptable quality, persons or organizations providing services must meet all licensing requirements of State or local health authorities. Persons and organizations shown below also must meet additional Medicare requirements before payments can be made for their services:

- Hospitals
- Skilled nursing facilities
- Home health agencies
- Independent diagnostic laboratories and organizations providing X-ray services
- Ambulance firms
- Chiropractors
- Independent physical therapists (those who furnish services in your home or in their offices)
- Facilities providing kidney dialysis or transplant services

All hospitals, skilled nursing facilities, and home health agencies participating in the Medicare program also must comply with title VI of the Civil Rights Act, which prohibits discrimination because of race, color, or national origin.

Except for certain situations described later in this handbook, Medicare cannot pay for care you get from a non-participating hospital, skilled nursing facility, or home health agency.

You should always make sure that the persons or organizations providing services are approved for Medicare payments. If you are not sure, ask them.

Two important rules

Under the law, Medicare does not cover care that is not "reasonable and necessary" for the treatment of an illness or injury. Medicare also does not cover care that is "custodial." These two rules are explained on this page and the next page.

Care that is not reasonable and necessary

If a doctor places you in a hospital or skilled nursing facility when the kind of care you need could be provided elsewhere, your stay would not be considered reasonable and necessary. So Medicare could not cover your stay. If you stay in a hospital or skilled nursing facility longer than you need to be there, Medicare payments would end at the time further inpatient care is no longer reasonable and necessary.

To help Medicare decide whether inpatient care is reasonable and necessary, each hospital and skilled nursing facility has a Utilization Review Committee, which is made up of at least two doctors. And in some parts of the country there are Professional Standards Review Organizations, which are made up of local doctors who review the care prescribed by their fellow doctors.

If a doctor (or other practitioner) comes to treat you or you visit him for treatment more often than is the usual medical practice in your area, Medicare would not cover the "extra" visits unless there are medical complications. Medicare cannot cover more services than are reasonable and necessary for your treatment. Any decision of this kind is always based on professional medical advice.

Some health care services and supplies are not generally accepted by the health community as being reasonable or necessary for diagnosis and treatment. This includes acupuncture, histamine therapy, and various kinds of medical equipment, for example. Medicare cannot cover services and supplies unless they are generally recognized as safe and effective by the health community.

Care that is custodial

Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training; for example, help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Even if you are in a participating hospital or skilled nursing facility or you are receiving care from a participating home health agency, Medicare does not cover your care if it is mainly custodial.

Your Medicare hospital insurance

Medicare's hospital insurance helps pay for three kinds of care. The three kinds of care are (1) inpatient hospital care; and, when medically necessary after a hospital stay, (2) inpatient care in a skilled nursing facility, and (3) home health care.

There is a limit on how many days of hospital or skilled nursing facility care and how many home health visits Medicare can help pay for in each benefit period.* However, your hospital insurance protection is renewed every time you start a new benefit period.

Medicare hospital insurance will pay for most but not all of the services you receive in a hospital or skilled nursing facility or from a home health agency. There are covered services and non-covered services under each kind of care. Covered services are services and supplies that hospital insurance can pay for.

***Benefit period**

A benefit period is a way of measuring your use of services under Medicare's hospital insurance. Your first benefit period starts the first time you enter a hospital after your hospital insurance begins. When you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge), a new benefit period starts the next time you go into a hospital. There is no limit to the number of benefit periods you can have.

The next two chapters tell you more about inpatient hospital care and inpatient care in a skilled nursing facility. Home health care is explained in the chapter beginning on page 34. There is a list of covered and non-covered services in each of these chapters.

You do not have to send us any bills for care you receive from a participating hospital, skilled nursing facility, or home health agency. Medicare will pay its share of the costs directly to the place where you received the care.

Whenever a hospital, skilled nursing facility, or home health agency sends Medicare a hospital insurance claim for payment, you will get a notice that explains the decision made on the claim and shows what Medicare paid. If you have any questions about the decision or the payment, get in touch with the intermediary that sent you the notice or call a social security office.

If you receive covered services from a non-participating hospital (see page 15) or from a Canadian or Mexican hospital (see page 16), the hospital can tell you about Medicare payment arrangements.

When you are a hospital inpatient

Medicare's hospital insurance can help pay for inpatient hospital care if **all** of the following four conditions are met: (1) a doctor prescribes inpatient hospital care for treatment of an illness or injury, (2) you require the kind of care that can only be provided in a hospital, (3) the hospital is participating in Medicare, and (4) the Utilization Review Committee of the hospital or a Professional Standards Review Organization does not disapprove your stay.

If your stay in a hospital is covered by Medicare, you are responsible for the first $104 in each benefit period. This is called the hospital insurance deductible. Medicare will pay for all other covered services for up to 60 days if your medical condition requires that you stay in the hospital that long.

From the 61st through the 90th day, hospital insurance pays for all covered services, *except for $26 a day.* Hospital insurance pays the rest of the cost for covered services during this time. (If you ever need more than 90 days of inpatient hospital care in a benefit period, see page 14 to find out how hospital reserve days can help with your expenses.)

Hospital insurance does **not** cover your doctor's services even though you receive them in a hospital. Doctors' services are covered under Medicare's medical insurance. Page 25 tells how medical insurance helps with doctor bills.

The tables on the following page show some of the services that are covered and services that are not covered when you are in the hospital.

Major services covered when you are a hospital inpatient

Medicare's hospital insurance can pay for these items.

1. A semiprivate room (2 to 4 beds in a room)
2. All your meals, including special diets
3. Regular nursing services
4. Costs of special care units, such as an intensive care unit, coronary care unit, etc.
5. Drugs furnished by the hospital during your stay
6. Lab tests included in your hospital bill
7. X-rays and other radiology services, including radiation therapy, billed by the hospital
8. Medical supplies such as casts, surgical dressings, and splints
9. Use of appliances, such as a wheelchair
10. Operating and recovery room costs
11. Rehabilitation services, such as physical therapy, occupational therapy, and speech pathology services

Some services not covered when you are a hospital inpatient

Medicare's hospital insurance **cannot** *pay for these items.*

1. Personal convenience items that you request such as a television, radio, or telephone in your room
2. Private duty nurses
3. Any extra charges for a private room, unless you need it for medical reasons
4. The first 3 pints of blood you receive in a benefit period (see page 38)

Hospital inpatient reserve days

We said earlier that Medicare will help pay for your care in a hospital for up to 90 days in each benefit period. But what happens if you have a long illness and have to stay in the hospital for more than 90 days? Medicare's hospital insurance includes an extra 60 hospital days you can use if this ever happens. These extra days are called reserve days.* You are responsible for no more than $52 a day for each reserve day you use. Hospital insurance pays the rest of the costs for covered services for each reserve day. **But once you use a reserve day you never get it back.** Reserve days are **not** renewable like your 90 hospital days in each benefit period.

***Reserve days**
Since you only have 60 reserve days in your lifetime, you can decide yourself when you want to use them. After you have been in the hospital 90 days, you can use all 60 reserve days at one time if you have to stay in the hospital that long. But you don't have to use your reserve days right away if you don't want to. Maybe you have private insurance that can help pay your hospital bill if an illness keeps you in the hospital for more than 90 days. If you don't want to use your reserve days, you must tell the hospital in writing ahead of time. Otherwise, the extra days you need to be in the hospital will be taken from your reserve days automatically.

Care in a non-participating hospital

Medicare's hospital insurance usually can help with your bills only if you are a patient in a participating hospital. However, hospital insurance can help pay for care in a qualified non-participating hospital if (1) you are admitted to the non-participating hospital for emergency treatment, and (2) the non-participating hospital is the closest one to get to that is equipped to handle the emergency. Under Medicare, emergency treatment means treatment that is immediately necessary to prevent death or serious impairment to health.

If the hospital does not submit the Medicare claim, any social security office will assist you in getting the hospital insurance payment for the covered care you received.

Care in a psychiatric hospital

Hospital insurance can help pay for **no more than** 190 days of care in a participating psychiatric hospital in your lifetime.

In addition, there is a special rule that applies if you are in a participating psychiatric hospital at the time your hospital insurance starts. The days you were an inpatient in the 150 days before your hospital insurance started must be subtracted from the days you could otherwise use in your first benefit period for inpatient psychiatric care. Any social security office can give you further information about this special rule.

Care in a foreign hospital

Medicare generally cannot pay for hospital or medical services outside the United States* except for care in qualified Canadian or Mexican hospitals in three specific situations. These are: (1) you are in the U.S. when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest U.S. hospital which can provide the emergency services you need, (2) you live in the U.S. and a Canadian or Mexican hospital is closer to your home than the nearest U.S. hospital which can provide the care you need, regardless of whether or not an emergency exists, and (3) you are in Canada traveling by the most direct route to or from Alaska and another State and an emergency occurs which requires that you be admitted to a Canadian hospital. (This provision does not apply if you are vacationing in Canada.)

When hospital insurance covers your inpatient stay in a Canadian or Mexican hospital, your medical insurance can cover necessary doctors' services and any required use of an ambulance. Any social security office will help you get Medicare payment for the covered services you receive.

Care in a Christian Science sanatorium

Medicare's hospital insurance can help pay for inpatient hospital and skilled nursing facility services you receive in a Christian Science sanatorium if it is operated, or listed and certified by, the First Church of Christ, Scientist, in Boston. You can get more information at any social security office.

***United States**
Puerto Rico, the Virgin Islands, Guam, and American Samoa are considered part of the United States, along with the 50 States and the District of Columbia.

Inpatient care in a skilled nursing facility

Medicare's hospital insurance can help pay for inpatient care in a participating skilled nursing facility* after you have been in a hospital. Hospital insurance can cover this care if you no longer need all the services that only a hospital can provide, but your condition still requires daily skilled nursing or rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility.

Hospital insurance can help pay for care in a skilled nursing facility if **all** of the following five conditions are met: (1) you have been in a hospital at least 3 days in a row (not counting the day of discharge) before your transfer to a participating skilled nursing facility, (2) you are transferred to the skilled nursing facility because you require care for a condition which was treated in the hospital, (3) you are admitted to the facility within a short time (generally within 14 days) after you leave the hospital, (4) a doctor certifies that you need, and you actually receive, skilled nursing or skilled rehabilitation services on a daily basis, and (5) the facility's Utilization Review Committee or a Professional Standards Review Organization does not disapprove your stay.

As we said, **all** five conditions must be met. But it's especially important to remember the requirement that you must need skilled nursing care or skilled rehabilitation services on a daily basis.

*Skilled nursing facility

A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation services as well as other related health services. In some facilities, only certain portions participate in Medicare. If you are not sure whether a facility or a particular portion participates in Medicare, ask someone at the facility or call a social security office.

By skilled nursing care, we mean care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist. The skilled nursing care and skilled rehabilitation services you receive must be under the general direction of a doctor.

Hospital insurance cannot pay for your stay if you are in a skilled nursing facility mainly because you need custodial care (see page 9). Also, hospital insurance cannot pay for your stay if you need skilled nursing or rehabilitation services only occasionally, such as once or twice a week.

When your stay in a skilled nursing facility is covered by Medicare, your hospital insurance can help pay for your care for up to 100 days in each benefit period, but **only** if you need daily skilled nursing care or rehabilitation services for that long.

If you leave a skilled nursing facility and are readmitted within 14 days, you do not have to have a new 3-day stay in the hospital in order for your care to be covered. If you have some of your 100 days left and you need skilled nursing or rehabilitation services on a daily basis for further treatment of a condition treated during your previous stay in the facility, your care can be covered.

In each benefit period, hospital insurance pays for all covered services for the first 20 days you are in a skilled nursing facility. After 20 days, hospital insurance pays for all covered services for the 21st through 100th day, *except for $13 a day*. Of course, if you receive any non-covered services, you are responsible for these costs.

Hospital insurance does **not** cover your doctor's services while you are in a skilled nursing facility. Medicare's medical insurance covers doctors' services. Page 25 tells you how medical insurance helps with doctor bills.

The tables below tell you some of the services that are covered and services that are not covered when you are in a skilled nursing facility.

Major services covered when you are in a skilled nursing facility

Medicare's hospital insurance can pay for these items.

1. A semiprivate room (2 to 4 beds in a room)
2. All your meals, including special diets
3. Regular nursing services
4. Rehabilitation services, such as physical, occupational, and speech therapy
5. Drugs furnished by the facility during your stay
6. Medical supplies such as splints and casts
7. Use of appliances such as a wheelchair

Some services not covered when you are in a skilled nursing facility

Medicare's hospital insurance **cannot** *pay for these items.*

1. Personal convenience items you request such as a television, radio, or telephone in your room
2. Private duty nurses
3. Any extra charges for a private room, unless you need it for medical reasons
4. The first 3 pints of blood you receive in a benefit period (see page 38)

Your Medicare medical insurance

Medicare's medical insurance can help pay for (1) doctors' services, (2) outpatient hospital care, (3) outpatient physical therapy and speech pathology services, (4) home health care, and (5) many other health services and supplies which are **not** covered by Medicare's hospital insurance.

The following chapters will tell you more about these different kinds of care, the services that are covered by medical insurance and those not covered, and what part of your medical expenses Medicare can pay.

As a general rule, after you have $60 in **reasonable charges** (see page 21) for covered medical expenses in each calendar year, your medical insurance will pay 80 percent of the reasonable charges for any additional covered services you receive during the rest of the year.

Your first $60 in covered expenses in each calendar year is called the medical insurance deductible. You need to meet this $60 deductible only once in a calendar year. The deductible can be met by any combination of covered expenses. You do not have to meet a separate deductible for each different kind of covered service you might receive. There is also a special carryover rule* that will help you if your medical expenses do not reach the deductible amount until the last 3 months of the year.

***Carryover rule**
If you have covered medical expenses in the last 3 months of a year that can be counted toward your $60 deductible for that year, they can also be counted toward your $60 deductible for the next year. This is true even if your total covered expenses for a year are less than $60. Any social security office can give you more information about the carryover rule.

Reasonable charges

Under the law, medical insurance payments are based on "reasonable charges" for covered services and supplies. Because of the way reasonable charges are determined, they may sometimes be less than the actual charges made by doctors and suppliers.*

The Medicare carrier for your area determines the reasonable charges for covered services and supplies on the basis of an annual review. New reasonable charges are put into effect about July 1 of each year, based on the actual charges made by physicians and suppliers in your area during the previous calendar year.

Here's how reasonable charges are determined.

First, the carrier determines the **customary** charge (generally the charge most frequently made) by each doctor and supplier for each separate service or supply furnished to patients in the previous calendar year.

Then, the carrier determines the **prevailing** charge for each covered service and supply. The prevailing charge is the amount which is high enough to cover the customary charges in three out of every four bills submitted in the previous year for each service and supply. However, increases in prevailing charges from year to year are limited by an "economic index" formula which relates doctors' fee increases to actual increases in the cost of maintaining a practice and raises in general earnings levels. This formula does not limit the amount a doctor may charge a patient. It only limits the amount Medicare can pay.

***Suppliers**
Suppliers are persons or organizations, other than doctors or health care facilities, that furnish equipment or services covered by medical insurance. For example, ambulance firms, independent laboratories, and organizations that rent or sell medical equipment are considered suppliers.

Whenever a medical insurance claim is submitted, the carrier compares the charge shown on the claim with the customary and prevailing charges for that service or supply. The charge approved by the carrier will be either the customary charge, the prevailing charge, or the actual charge, **whichever is lowest.**

If the actual charge by your doctor or supplier is higher than the reasonable charge, it may be because he recently raised his charge and it has not been in effect long enough to be included in Medicare's annual review. In other cases, of course, the actual amount billed may be more than the reasonable charge because the doctor or supplier has higher charges for the particular service or supply than most other doctors and suppliers in your area. Or, the doctors in your area may have increased some of their charges by larger amounts than Medicare can recognize under the "economic index" formula in the law.

When a doctor or supplier accepts an assignment of the medical insurance payment (see page 24), he also agrees to accept the reasonable charge as his total charge to you for covered services. For this reason, you may want to find out in advance whether the doctor or supplier will accept assignment.

How medical insurance payments are made

There are two ways payments are made under Medicare's medical insurance. The medical insurance payment can be made to the doctor or supplier. This payment method is called assignment. Or, the medical insurance payment can be made to you.

After you or the doctor or supplier sends in a medical insurance claim, Medicare will send you an *Explanation of Medicare Benefits Notice** to tell you the decision on the claim.

***Explanation of Medicare Benefits Notice**
Medicare will send this notice to you whenever a medical insurance claim is submitted, whether you send in the claim yourself or it is submitted by a doctor or supplier. The notice shows what expenses were covered, what charges were approved, how much was credited toward your $60 deductible, and the amount Medicare paid. If there is anything on the notice that you don't understand, you can get an explanation from the carrier that sent you the notice or from any social security office.

Assignment

The assignment method, in which the doctor or supplier receives the medical insurance payment, can be used **only** if you both agree to it. If the doctor or supplier is willing to use the assignment method, he also agrees that his total charge for the covered service will not exceed the reasonable charge set by the Medicare carrier. Medicare then pays your doctor or supplier 80 percent of the reasonable charge, after subtracting any part of the $60 deductible you have not met. The doctor or supplier can charge you **only** for any of the $60 deductible not yet met and for the co-insurance, which is the remaining 20 percent of the reasonable charge. Of course, your doctor also can charge you for any services that Medicare does not cover.

Payment to you

Medicare makes direct payment to you covering 80 percent of the reasonable charges, after subtracting any part of the $60 deductible you haven't met. Charges to you by the doctor or supplier are not limited to the reasonable charge set by the Medicare carrier.

See page 48 to find out how to send in a claim for medical insurance payment.

When a doctor treats you

Medical insurance can help pay for covered services you receive from your doctor in his office, in a hospital, in a skilled nursing facility, in your home, or any other location in the U.S. Your medical insurance can also help pay for doctors' services you receive in connection with covered inpatient care in a Canadian or Mexican hospital. See page 16 to find out about care in Canadian and Mexican hospitals.

After you meet the $60 yearly medical insurance deductible, medical insurance pays 80 percent of the reasonable charges for covered services you receive from your doctor.

Payment can be made either to you or to your doctor. Page 24 describes the two payment methods.

Radiology and pathology services by doctors

While you are an inpatient in a hospital, medical insurance pays 100 percent of the reasonable charges for services by doctors in the fields of radiology and pathology, even if you haven't met your medical insurance deductible for the year. Because the full reasonable charges are paid, they do not count toward meeting your $60 deductible.

Outpatient treatment of mental illness

Doctors' services you receive for outpatient treatment of a mental illness are covered, but medical insurance can pay **no more than** $250 in any one year for these services.

Chiropractors' services

Medical insurance helps pay for only one kind of treatment furnished by a licensed and Medicare-certified chiropractor. The **only** treatment that can be covered is manual manipulation of the spine to correct a subluxation that can be demonstrated by X-ray. Medical insurance does not pay for the X-ray or for any other diagnostic or therapeutic services furnished by a chiropractor.

Podiatrists' services

Medical insurance can help pay for any covered services of a licensed podiatrist, except for routine foot care. Routine foot care includes hygienic care; treatment for flat feet or other structural misalignments of the feet; and removal of corns, warts (including plantar warts), and calluses. However, medical insurance can help pay for routine foot care **if** you have a medical condition affecting the lower limbs (such as severe diabetes) which requires that such care be performed by a podiatrist or a doctor of medicine or osteopathy.

Dental care

Medical insurance can help pay for dental care **only** if it involves surgery of the jaw or related structures or setting fractures of the jaw or facial bones. Care in connection with the treatment, filling, removal or replacement of teeth; root canal therapy, surgery for impacted teeth; and other surgical procedures involving the teeth or structures directly supporting teeth are **not** covered.

The tables below show some of the doctors' services that are covered and some that are not covered by medical insurance.

Major doctors' services covered by medical insurance
Medicare's medical insurance can help pay for:

1 Medical and surgical services
2 Diagnostic tests and procedures that are part of your treatment
3 Other services which are ordinarily furnished in the doctor's office and included in his bill, such as:
   - ► X-rays you receive as part of your treatment
   - ► Services of your doctor's office nurse
   - ► Drugs and biologicals that cannot be self-administered
   - ► Medical supplies
   - ► Physical therapy and speech pathology services

Some doctors' services not covered by medical insurance
Medicare's medical insurance **cannot** *pay for these services.*

1 Routine physical examinations
2 Routine foot care
3 Eye or hearing examinations for prescribing or fitting eyeglasses or hearing aids
4 Immunizations (unless required because of an injury or immediate risk of infection)
5 Cosmetic surgery unless it is needed because of accidental injury or to improve the functioning of a malformed part of the body

Outpatient hospital services

Medicare's medical insurance helps pay for covered services you receive as an outpatient from a participating hospital for diagnosis or treatment of an illness or injury.

Medical insurance pays the hospital 80 percent of the reasonable charges for covered services you receive as an outpatient after subtracting any of the $60 deductible you have not met. The hospital will apply for the medical insurance payment and will charge you for any part of the deductible you have not met plus 20 percent of the remaining reasonable charges.

When you go to a hospital for outpatient services, be sure to show the people there your most recent *Explanation of Medicare Benefits Notice*. From this form, they can tell how much of the $60 deductible you have met and how much of the deductible, if any, they may charge you.

If the hospital cannot tell how much of the $60 deductible you have met and the charge for the services you received is less than $60, the hospital may ask you to pay the entire bill. If you pay the bill, any medical insurance payments that are due will be paid directly to you. Usually, the hospital will prepare the medical insurance claim for you. But if you ever need help with a claim, get in touch with any social security office.

Under certain conditions, medical insurance can also help pay for emergency outpatient care you receive from a non-participating hospital.

The tables below tell you some of the outpatient hospital services that are covered and the services that are not covered by medical insurance.

Major outpatient hospital services covered by medical insurance

Medicare's medical insurance helps pay for these items.

1. Services in an emergency room or outpatient clinic
2. Laboratory tests billed by the hospital
3. X-rays and other radiology services billed by the hospital
4. Medical supplies such as splints and casts
5. Drugs and biologicals which cannot be self-administered

Some outpatient hospital services not covered by medical insurance

Medicare's medical insurance **cannot** *pay for these items.*

1. Routine physical examinations and tests directly related to such examinations
2. Eye or ear examinations to prescribe or fit eyeglasses or hearing aids
3. Immunizations (unless required because of an injury or immediate risk of infection)
4. Routine foot care

Outpatient physical therapy and speech pathology services

Medicare's medical insurance can help pay for medically necessary outpatient physical therapy or speech pathology services. There are three different ways you can receive these services under medical insurance.

You may receive physical therapy or speech pathology services as part of your treatment in a doctor's office. In this case, the doctor must include the charge for the services in his bill. Medical insurance will pay 80 percent of the reasonable charges after the $60 yearly deductible has been met. Either you or the doctor can submit the claim as described on page 48.

You may receive services directly from an independently practicing, Medicare-certified physical therapist in his office or in your home if such treatment is prescribed by a doctor. Your medical insurance will pay 80 percent of the reasonable charges after the $60 yearly deductible, but can pay **no more than** $80 in total benefits in any one year. Either you or the physical therapist can submit the claim as described on page 48.

You may receive physical therapy or speech pathology services as an outpatient of a participating hospital or skilled nursing facility, or from a home health agency, clinic, rehabilitation agency, or public health agency approved by Medicare if these services are furnished under a plan your doctor sets up and periodically reviews. In this case, the organization providing services always submits the claim and may only charge you for any part of the $60 deductible you have not met, 20 percent of the remaining reasonable charges, and for any non-covered services.

Other services and supplies covered by medical insurance

Medicare's medical insurance also helps pay for other services and supplies described in this chapter. Medical insurance will pay 80 percent of the reasonable charges for these covered services and supplies after you have met the $60 yearly deductible. Usually when these services and supplies are furnished by a hospital, skilled nursing facility, or home health agency, it will make the claim for medical insurance payment. Otherwise, you or the supplier submits the claim. Page 48 tells you how medical insurance claims are submitted.

Independent laboratory services

Medical insurance can help pay for diagnostic tests provided by independent laboratories. The laboratory must be certified by Medicare for the services you receive. Not all laboratories are certified by Medicare and some laboratories are certified only for certain kinds of tests. Your doctor can usually tell you which laboratories are certified and whether the tests he is prescribing from a certified laboratory are covered by your medical insurance.

Ambulance transportation

Medical insurance can help pay for ambulance transportation **only** if (1) the ambulance, equipment, and personnel meet Medicare requirements and (2) transportation in any other vehicle could endanger the patient's health.

Under these conditions, medical insurance can help pay for ambulance transportation from the scene of an accident to a hospital, from your home to a hospital or skilled nursing facility, between hospitals and skilled nursing facilities, or from a hospital or skilled nursing facility to your home.

Medical insurance usually can help pay for ambulance transportation only in your local area. However, if there are no facilities in the local area equipped to provide the care you need, medical insurance will help pay for necessary ambulance transportation to the closest facility outside your local area that can provide the necessary care. If you choose to go to another institution that is farther away, Medicare payment still will be based on the reasonable charge for transportation to this closest facility.

Necessary ambulance services in connection with a covered inpatient stay in a Canadian or Mexican hospital (see page 16) can also be covered by medical insurance.

Prosthetic devices

Medical insurance helps pay for prosthetic devices needed to substitute for an internal body organ. These include, for example, heart pacemakers, corrective lenses needed after a cataract operation, and colostomy or ileostomy bags and certain related supplies. Medical insurance can also help pay for artificial limbs and eyes, and for arm, leg, back, and neck braces. Orthopedic shoes are covered only when they are part of leg braces. Dental plates or other dental devices are not covered.

Durable medical equipment

Medical insurance can help pay for durable medical equipment such as oxygen equipment, wheelchairs, home dialysis systems, and other medically necessary equipment that your doctor prescribes for use in your home. (A facility that mainly provides skilled nursing or rehabilitation services cannot be

considered your home.) You can rent or buy this equipment. Whether you rent or buy, Medicare usually makes payments monthly. If you rent, medical insurance will help pay the reasonable rental charges for as long as the equipment is medically necessary. If you buy, whether you pay the entire purchase price in a lump sum or pay in installments, medical insurance will make monthly payments until its share of the reasonable purchase price is paid or until the equipment is no longer medically necessary, whichever comes first.

Portable diagnostic X-ray services

Medical insurance helps pay the reasonable charges for portable diagnostic X-ray services you receive in your home if they are ordered by a doctor and if they are provided by a Medicare-certified supplier.

Medical supplies

Medical insurance can also help pay for surgical dressings, splints, casts, and similar medical supplies ordered by a doctor in connection with your medical treatment. This does not include adhesive tape, antiseptics, or other common first-aid supplies.

Home health care under Medicare

Sometimes people are confined to their homes because of an illness or injury and need skilled health services only on a part-time basis. These services may be medically necessary, for example, after treatment in a hospital or skilled nursing facility. Or, part-time skilled care provided at home could help avoid an inpatient stay.

If you need part-time skilled health care in your home for the treatment of an illness or injury, either hospital insurance or medical insurance can help pay for covered health care services furnished by home health agencies* participating in Medicare. (A facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

Medicare does not cover home care services furnished primarily to assist people in meeting personal, family, and domestic needs. These services include general household services, preparing meals, shopping, or assisting in bathing, dressing, or other personal needs.

When care in your home is covered by Medicare, the services you receive are counted in visits. For example, if you receive one home health service twice in the same day, or two different home health services in the same day, two visits would be counted.

***Home health agencies**
A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy, in your home.

The tables below tell you the home health services Medicare covers and the services that are not covered.

Home health services covered by Medicare
Medicare can pay for:

1 Part-time skilled nursing care
2 Physical therapy
3 Speech therapy

If you need part-time skilled nursing care, physical therapy, or speech therapy, Medicare can also pay for:

- ► Occupational therapy
- ► Part-time services of home health aides
- ► Medical social services
- ► Medical supplies and equipment provided by the agency

Home health services not covered by Medicare
Medicare **cannot** *pay for these items.*

1 Full-time nursing care at home
2 Drugs and biologicals
3 Meals delivered to your home
4 Homemaker services

When hospital insurance pays for home health care

Medicare's hospital insurance can pay for home health visits if six conditions are met. **All** six conditions must be met. These conditions are: (1) you were in a qualifying hospital for at least 3 days in a row (not counting the day of discharge), (2) the home health care is for further treatment of a condition which was treated in a hospital or skilled nursing facility, (3) the care you need includes part-time skilled nursing care, physical therapy, or speech therapy, (4) you are confined to your home, (5) a doctor determines you need home health care and sets up a home health plan for you within 14 days after your discharge from a hospital or participating skilled nursing facility, and (6) the home health agency providing services is participating in Medicare.

Under these conditions, hospital insurance can pay the full cost of up to 100 home health visits after the start of one benefit period and before the start of another. Payment for these visits can be made for up to 12 months after your most recent discharge from a hospital or participating skilled nursing facility. You may be charged only for any non-covered services you receive.

The home health agency will submit the claim for payment. You don't have to send in any bills yourself.

When medical insurance pays for home health care

Medicare's medical insurance can help pay for up to 100 home health visits in a calendar year. You do not have to have a 3-day stay in the hospital for medical insurance to pay for home health care. But medical insurance can pay for the visits only if four conditions are met. **All** four conditions must be met. These conditions are: (1) you need part-time skilled nursing care or physical or speech therapy, (2) a doctor determines you need the services and sets up a plan for home health care, (3) you are confined to your home, and (4) the home health agency providing services is participating in Medicare. Medical insurance also can pay for home health visits if you have used up the 100 visits covered under hospital insurance and need more visits.

After you meet the $60 yearly deductible, medical insurance pays the full costs for covered home health services in each calendar year. You may be charged only for any non-covered services you receive.

The home health agency always submits the medical insurance claim for home health care. You don't have to send in any bills yourself.

Coverage of blood under Medicare

Both hospital insurance and medical insurance can help pay for blood, except for the first 3 pints (or equivalent units of packed red blood cells) you use under each part of your Medicare insurance. You will not have to pay for these 3 pints if you can arrange for blood replacement.*

If you need blood while you are an inpatient in a hospital or a skilled nursing facility, you are responsible for the first 3 pints of blood in each benefit period. After that, hospital insurance pays the full cost of any additional blood you need during that benefit period.

If you are receiving blood as an outpatient or as part of other services covered by your medical insurance, you are responsible for the first 3 pints of blood in each calendar year. After that, your medical insurance will pay 80 percent of the reasonable charges, after you have met the $60 annual deductible, for any additional blood you receive as an outpatient during the year.

***Blood**
If you are covered by a blood donor plan, it can replace the first 3 pints of blood for you. Or, you can arrange to have someone donate blood for you.

Your right of appeal

If you disagree with a decision on the amount Medicare will pay on a claim or whether services you received are covered by Medicare, you always have the right to ask for a review of the decision.

Under Medicare's hospital insurance, the health facility that provides the services submits the claim for payment. But, Medicare will send you a notice of the decision made on the claim. If you feel that the decision is not correct, you can ask for a review of the claim. Any social security office can help you request a review. If you are still not satisfied after the review and if the amount in question is $100 or more, you can ask for a formal hearing. Cases that involve $1,000 or more can eventually be appealed to a Federal court.

Under Medicare's medical insurance, whether you or the doctor or supplier submits the claim for payment, Medicare will send you a notice of the decision made on the claim. If you disagree with the decision, you can ask the Medicare carrier that handled the claim to review it. Then, if you still disagree with the decision and if the amount in question is $100 or more, you can request a hearing by the carrier.

The notice you receive from Medicare which tells you of the decision made on your claim will also tell you exactly what appeal steps you can take. If you ever need more information about your right of appeal and how to request it, get in touch with any social security office.

Waiver of beneficiary liability

Under the law, Medicare cannot pay for custodial care or other services that are not reasonable and necessary (see page 8). For example, if you go into a hospital when the kind of services you need could be provided in a less expensive health facility, on an outpatient basis, or in your home, Medicare will not pay for the hospital services. Or, for example, if your doctor gives you services that are in excess of accepted standards of medical practice in your area for similar medical conditions, Medicare will not pay for the excess services.

But there is also a provision in the Medicare law that says you will not be held responsible for paying for such services if you could not reasonably be expected to know they were not covered by Medicare.

This provision of the law is called "waiver of beneficiary liability." Waiver only applies, however, when Medicare denies payment on a claim because it is decided that the services you received were custodial or that they were not reasonable or necessary for diagnosis or treatment. In addition, the waiver provision does not apply to medical insurance claims unless the doctor or other person who furnished the services agreed to payment under the assignment method.

If you are a member of a prepayment plan

Prepayment plans make health services available to their members in a special way. Generally, each member pays regular premiums to the plan. The member can then receive health services the plan provides, whenever he needs them, without additional charges. In some plans, small charges are made for certain services, such as drugs or home visits.

Many prepayment plans have made arrangements with Medicare to receive direct payments for services they furnish which are covered under the medical insurance part of Medicare. Some prepayment plans have contracts with Medicare as Health Maintenance Organizations and can receive direct payment for services covered by either hospital insurance or medical insurance.

If you are a member of a prepayment plan, ask the people in charge of the plan what arrangements have been made for Medicare payments. Find out, too, what you should do when you get health services that are not provided by the plan.

If you are interested in finding out whether there are any Health Maintenance Organizations or other types of prepayment plans in your area, contact any social security office.

What Medicare does not cover

This alphabetical list shows most of the major services and supplies that Medicare usually does not pay for. Items shown in blue can be covered by Medicare only under the conditions described here or on the pages indicated.

Acupuncture

Chiropractic services
(See page 26)

Christian Science practitioners' services

Cosmetic surgery
(See page 27)

Custodial care
(See page 9)

Dental care
(See page 26)

Drugs and medicines you buy yourself with or without a doctor's prescription

Eyeglasses and eye examinations for prescribing, fitting, or changing eyeglasses

Foot care that is routine
(See page 26)

Foreign health care
(See page 16)

Hearing aids and hearing examinations for prescribing, fitting, or changing hearing aids

Homemaker services
(See page 34)

Immunizations unless required because of an injury or immediate risk of infection

Injections which can be self-administered, such as insulin

Meals delivered to your home

Naturopaths' services

Nursing care on a full-time basis in your home

Orthopedic shoes (unless part of a leg brace) and other supportive devices for the feet

Personal convenience items that you request such as a phone, radio, or television in your room at a hospital or skilled nursing facility

Physical examinations that are routine and tests directly related to such examinations

Private duty nurses

Private room (See table on page 13 or 19)

Services performed by immediate relatives or members of your household

Services which are not reasonable and necessary (See page 8)

Services payable by workmen's compensation or another government program

Services for which neither the patient nor another party on his behalf has a legal obligation to pay

How to get the part of Medicare you do not have

Most people who have Medicare's hospital insurance do not pay monthly premiums for this protection. They have hospital insurance because of credits for work under social security.

If you have Medicare hospital insurance, but do not have the medical insurance part of Medicare, you can sign up for medical insurance in the first 3 months of any year. Generally, for each year you delay signing up after you were first eligible to enroll, your monthly medical insurance premium* increases by 10 percent. Your protection does not start until July 1 of the year you sign up.

***Medical insurance premium**

The basic monthly medical insurance premium is $6.70 through June 30, 1976. It will be increased to $7.20 a month for the 12-month period starting July 1, 1976. Under the law the premium can be raised only if there has been a general increase in social security cash benefits during the previous year. Also, the premium increase cannot be more than the percentage increase in cash benefits. Your medical insurance premium is less than one-half the cost of your medical insurance protection.

If you are 65 or older and have Medicare medical insurance, but not the hospital insurance part, you can get hospital insurance by paying a monthly premium. You can sign up for hospital insurance in the first 3 months of any year. Generally, for each year you delay signing up after you become 65, the hospital insurance premium* goes up by 10 percent. Your protection does not begin until July 1 of the year you sign up.

Your social security office can answer any questions you may have on how to get the part of Medicare you do not have now.

***Hospital insurance premium**

The basic monthly hospital insurance premium is $40 through June 30, 1976. It will be increased to $45 a month for the 12-month period starting July 1, 1976. This premium represents the present cost of Medicare hospital insurance protection. This premium may go up if the costs of hospital care rise. Under the law, however, hospital insurance premiums cannot be changed more often than once a year.

Events that can end your Medicare protection

If you are 65 or older and you have Medicare hospital insurance because of work credits under social security, you will have this protection as long as you live. Your medical insurance protection, however, depends on the payment of monthly premiums, which are either deducted from social security checks or paid directly.

Medical insurance can stop only if you do not pay premiums or if you voluntarily cancel. Remember, though, that you may not be able to get private insurance that offers the same protection. Also, you can re-enroll only once, and your premium will be higher.

If you are buying hospital insurance protection, you cannot cancel your medical insurance without losing your hospital insurance, too. However, you can cancel your hospital insurance and still continue your medical insurance.

If you want more information about cancelling your Medicare protection, get in touch with any social security office.

If you are disabled

If you have Medicare because you are disabled, both your hospital and your medical insurance protection will end if your entitlement to disability benefits ends before you are 65. Your Medicare protection will continue for one calendar month after the month notice is sent to you that you are no longer entitled to disability payments.

As long as you are getting disability checks, you will have the protection of hospital insurance. If for any reason you ever want to cancel your medical insurance, get in touch with any social security office.

If you have Medicare because of chronic kidney disease

If you are under 65 and you have Medicare because of chronic kidney disease, your protection will continue until 12 months after the month you have a kidney transplant or 12 months after the month maintenance dialysis treatment ends. Your medical insurance protection could stop before that if you fail to pay premiums or you decide to cancel. Get in touch with any social security office if you ever want to end your medical insurance protection.

How to submit medical insurance claims

A *Request for Medicare Payment* form, also called Form 1490, must be filled out and submitted in order for Medicare to pay for services of doctors and suppliers which are covered by your medical insurance. All social security offices, and most doctors' offices, have copies of the form. Instructions on how to fill it out are on the back of the form.

If the doctor or supplier is willing to use the assignment method of payment, he submits the claim. You complete and sign Part I of the form. He completes Part II and sends in the form.

If the doctor or supplier does not accept assignment, you submit the claim under the payment-to-you method. Complete and sign Part I of the form. Ask the person who provided the services either to complete Part II of the form **or** to give you an itemized bill to send in with the form. An itemized bill **must** show (1) the date you received the services, (2) the place where you received the services, (3) a description of the services, (4) the nature of your illness or injury (diagnosis), (5) the charge for each service, and (6) your name **and** your health insurance claim number, **including** the letter at the end of the number. If the bill doesn't include all of this information, your payment will be delayed.

If you are sending in itemized bills, you may submit a number of bills with a single *Request for Medicare Payment* form. It doesn't matter whether all the bills are from one doctor or supplier or from different people who gave you services.

Before any medical insurance payment can be made, your record must show that you have met the yearly deductible. So, as soon as your bills come to $60, send them to the carrier that handles your medical insurance claims with a *Request for Medicare Payment* form. Once you have met the $60

deductible, we suggest that you send in your future bills for covered services as soon as you get them so that Medicare payment can be made promptly. Page 51 will tell you where to send your claim.

If your total medical bills for the year are less than $60, medical insurance cannot pay any part of your bills for that year. However, any covered medical expenses you have in the last 3 months of a year that could be counted toward your deductible for that year can also be counted toward your deductible for the next year. So, even if your expenses for the year total less than $60, you should send in covered bills you have in the last 3 months of the year. You can send them in with your first covered bill the following year.

It's a good idea to keep a record of your medical insurance claim in case you ever want to inquire about it. Before you send in a claim, write down the date you mail it, the services you received, the date and charges for each service, and the name of the person who provided each service.

Claims for a person who died

When someone who has Medicare dies, any hospital insurance payments due will be paid directly to the hospital, skilled nursing facility, or home health agency that provided covered services.

For services covered under medical insurance which were furnished by doctors or suppliers, some special rules apply. If the doctor or supplier accepts an assignment, the medical insurance payment can be made directly to him. If the doctor or supplier will not accept an assignment, then any medical insurance payment due will be paid to whoever pays the bill and submits a medical insurance claim with proof of payment. The person who pays the bill will need to file two forms. One

form, called *Request for Medicare Payment*, is explained on page 48. The other form is called *Statement Regarding Medicare Payment for Medical Services to Deceased Patient.* Copies of both forms can be obtained at any social security office.

If the patient paid the bill prior to his or her death, call any social security office for information about how to get the medical insurance payment.

Time limits for submitting claims

Under the law, there are some time limits for submitting medical insurance claims. For medical insurance to make payments on your claims, you must send in your claims within these time limits. You always have at least 15 months to submit claims. The table below tells you exactly what the time limits are.

When you receive services	When your claim must be submitted
Between October 1, 1974, and September 30, 1975	By December 31, 1976
Between October 1, 1975, and September 30, 1976	By December 31, 1977
Between October 1, 1976, and September 30, 1977	By December 31, 1978
Between October 1, 1977, and September 30, 1978	By December 31, 1979

Where to send your medical insurance claims

The list beginning on the next page gives the names and addresses of the organizations selected by the Social Security Administration to handle medical insurance claims. These organizations are called carriers. In most cases, one carrier handles claims for an entire State. But some carriers handle claims for only part of a State. To find out where to send your medical insurance claim, look in the list for the State **where you received the services.** Under the name of the State, you will find the name of the carrier that will handle your claim. If there is more than one carrier in the State, look for the **county** where you received services to find the carrier that will handle your claim. (See page 48 to find out how to submit medical insurance claims.)

If you are not sure where to send your first claim and happen to send it to the wrong office, your claim will be sent on to the right place.

Whenever you send in a claim, be sure to include the word Medicare in the carrier's address on the envelope. Also, be sure to put **your** return address on the envelope.

After you make a claim, the carrier will usually send you another *Request for Medicare Payment* form for your next claim. The form will usually show the carrier's name and address in the top left-hand corner. If you ever need to file a medical insurance claim and don't have a claim form, you can get one by phoning a social security office.

Note: If you are entitled to Medicare under the railroad retirement system, send your medical insurance claims to The Travelers Insurance Company office which is nearest to your home—no matter where you received services.

Alabama
Medicare
Blue Cross-Blue Shield of Alabama
930 South 20th Street
Birmingham, Alabama 35205

Alaska
Medicare
Aetna Life & Casualty
Crown Plaza
1500 S.W. First Avenue
Portland, Oregon 97201

Arizona
Medicare
Aetna Life & Casualty
Medicare Claim Administration
3010 West Fairmount Avenue
Phoenix, Arizona 85017

Arkansas
Medicare
Arkansas Blue Cross and
Blue Shield
P.O. Box 2181
Little Rock, Arkansas 72203

California
Counties of: Los Angeles, Orange, San Diego, Ventura, San Bernadino, Imperial, San Luis Obispo, Riverside, Santa Barbara
Medicare
Occidental Life Insurance Co. of California
Box 54905
Terminal Annex
Los Angeles, California 90054

Rest of State:
Medicare
Blue Shield of California
P.O. Box 7968, Rincon Annex
San Francisco, California 94120

Colorado
Medicare
Colorado Medical Service, Inc.
700 Broadway
Denver, Colorado 80203

Connecticut
Medicare
Connecticut General Life
Insurance Co.
200 Pratt Street
Meriden, Connecticut 06450

Delaware
Medicare
Blue Cross and Blue Shield of Delaware
201 West 14th Street
Wilmington, Delaware 19899

District of Columbia
Medicare
Medical Service of D.C.
550 – 12th St., S.W.
Washington, D.C. 20024

Florida
Counties of: Dade, Monroe
Medicare
Group Health, Inc.
P.O. Box 341370
Miami, Florida 33134

Rest of State:
Medicare
Blue Shield of Florida, Inc.
P.O. Box 2525
Jacksonville, Florida 32203

Georgia
The Prudential Insurance Co. of America
Medicare Part B
P.O. Box 95466 Executive Park Station
Atlanta, Georgia 30347

Hawaii
Medicare
Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812

Idaho
Medicare
The Equitable Life Assurance Society
P.O. Box 8048
Boise, Idaho 83707

Illinois
Cook County
Medicare Part B
Illinois Medical Service
P.O. Box 210
Chicago, Illinois 60690

Rest of State:
Medicare
CNA Insurance
Medicare Benefits Division
P.O. Box 910
Chicago, Illinois 60690

Indiana
Medicare Part B
120 West Market Street
Indianapolis, Indiana 46204

Iowa
Medicare
Blue Shield of Iowa
636 Grand Avenue
Des Moines, Iowa 50307

Kansas
Counties of: Johnson, Wyandotte
Medicare
Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Rest of State:
Medicare
Kansas Blue Shield
P.O. Box 239
Topeka, Kansas 66601

Kentucky
Medicare
Metropolitan Life Insurance Co.
1218 Harrodsburg Road
Lexington, Kentucky 40504

Louisiana
Medicare
Pan-American Life Insurance Co.
P.O. Box 60450
New Orleans, Louisiana 70160

Maine
Medicare
Union Mutual Life Insurance Co.
Box 4629
Portland, Maine 04112

Maryland
Counties of: Montgomery, Prince Georges
Medicare
Medical Service of D.C.
550 – 12th St., S.W.
Washington, D.C. 20024

Rest of State:
Maryland Blue Shield, Inc.
700 East Joppa Road
Towson, Maryland 21204

Massachusetts
Medicare
Blue Shield of Massachusetts, Inc.
P.O. Box 2137
Boston, Massachusetts 02106

Michigan
Medicare
Blue Shield of Michigan
P.O. Box 2201
Detroit, Michigan 48231

Minnesota
Counties of: Anoka, Dakota, Filmore, Goodhue, Hennepin, Houston, Olmstead, Ramsey, Wabasha, Washington, Winona
Medicare
The Travelers Insurance Company
8120 Penn Avenue, South
Bloomington, Minnesota 55431

Rest of State:
Medicare
Blue Shield of Minnesota
P.O. Box 8899
Minneapolis, Minnesota 55408

Mississippi
Medicare
The Travelers Insurance Co.
P.O. Box 22545
Jackson, Mississippi 39205

Missouri
Counties of: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, Worth
Medicare
Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Rest of State:
Medicare
General American Life
Insurance Co.
P.O. Box 505
St. Louis, Missouri 63166

Montana
Medicare
Montana Physicians' Service
P.O. Box 2510
Helena, Montana 59601

Nebraska
Medicare
Mutual of Omaha Insurance Co.
P.O. Box 456, Downtown Station
Omaha, Nebraska 68101

Nevada
Medicare
Aetna Life & Casualty
1535 Vassar Street
P.O. Box 3077
Reno, Nevada 89505

New Hampshire
Medicare
New Hampshire-Vermont
Physician Service
Two Pillsbury Street
Concord, New Hampshire 03301

New Jersey
Medicare
The Prudential Insurance Co.
of America
P.O. Box 3000
Linwood, New Jersey 08221

New Mexico
Medicare
The Equitable Life Assurance
Society
P.O. Box 3070, Station D
Albuquerque, New Mexico 87110

New York
Counties of: Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester
Medicare
Blue Cross-Blue Shield of
Greater New York
Two Park Avenue
New York, New York 10016

County of: Queens
Medicare
Group Health, Inc.
P.O. Box 233—Midtown Station
New York, New York 10018

Counties of: Livingston, Monroe, Ontario, Seneca, Wayne, Yates
Medicare
Genesee Valley Medical Care, Inc.
41 Chestnut Street
Rochester, New York 14647

Counties of: Allegany, Cattaraugus, Erie, Genesee, Niagara, Orleans, Wyoming
Medicare
Blue Shield of Western
New York, Inc.
298 Main Street
Buffalo, New York 14202

Counties of: Albany, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Cortland, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Steuben, St. Lawrence, Tioga, Tompkins, Warren, Washington
Medicare
Metropolitan Life Insurance Co.
276 Genesee Street
P.O. Box 393
Utica, New York 13503

North Carolina
The Prudential Insurance Co.
of America
Medicare B Division
P.O. Box 2126
High Point, North Carolina 27261

North Dakota
Medicare
Blue Shield of North Dakota
301 Eighth Street, South
Fargo, North Dakota 58102

Ohio
Medicare
Nationwide Mutual Insurance Co.
P.O. Box 57
Columbus, Ohio 43216

Oklahoma
Medicare
Aetna Life & Casualty
1140 N.W. 63rd Street
Oklahoma City, Oklahoma 73116

Oregon
Medicare
Aetna Life & Casualty
Crown Plaza
1500 S.W. First Avenue
Portland, Oregon 97201

Pennsylvania
Medicare
Pennsylvania Blue Shield
Box 65 Blue Shield Bldg.
Camp Hill, Pennsylvania 17011

Rhode Island
Medicare
Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

South Carolina
Medicare
Blue Shield of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29260

South Dakota
Medicare
South Dakota Medical Service, Inc.
711 North Lake Avenue
Sioux Falls, South Dakota 57104

Tennessee
Medicare
The Equitable Life
Assurance Society
P.O. Box 1465
Nashville, Tennessee 37202

Texas
Medicare
Group Medical and Surgical Service
P.O. Box 22147
Dallas, Texas 75222

Utah
Medicare
Blue Shield of Utah
P.O. Box 270
2455 Parley's Way
Salt Lake City, Utah 84110

Vermont
Medicare
New Hampshire-Vermont
Physician Service
Two Pillsbury Street
Concord, New Hampshire 03301

Virginia
Counties of: Arlington, Fairfax
Cities of: Alexandria, Falls Church, Fairfax
Medicare
Medical Service of D.C.
550-12th St., S.W.
Washington, D.C. 20024

Rest of State:
Medicare
The Travelers Insurance Co.
P.O. Box 26463
Richmond, Virginia 23261

Washington
Medicare
Washington Physicians' Service
Mail to your local
Medical Service Bureau
If you do not know which bureau handles your claim, mail to:
Medicare Washington Physicians' Service, 220 West Harrison, Seattle, Washington 98119

West Virginia
Medicare
Nationwide Mutual Insurance Co.
P.O. Box 57
Columbus, Ohio 43216

Wisconsin
County of Milwaukee
Medicare
Surgical Care—Blue Shield
P.O. Box 2049
Milwaukee, Wisconsin 53201

Rest of State:
Medicare
Wisconsin Physicians Service
Box 1787
Madison, Wisconsin 53701

Wyoming
Medicare
The Equitable Life
Assurance Society
P.O. Box 628
Cheyenne, Wyoming 82001

Puerto Rico
Medicare
Seguros De Servicio De Salud De Puerto Rico
P.O. Box 3628
104 Ponce de Leon Avenue
Hato Rey, Puerto Rico 00936

Virgin Islands
Medicare
Seguros De Servicio De Salud De Puerto Rico
P.O. Box 3628
104 Ponce de Leon Avenue
Hato Rey, Puerto Rico 00936

American Samoa
Medicare
Hawaii Medical Service Assn.
P.O. Box 860
Honolulu, Hawaii 96808

Guam
Medicare
Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812

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